

EMPLOYER'S ADMISSION OF EMPLOYEE'S RIGHT TO COMPENSATION (G.S. §97-18(b))

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employer FEIN _____

Employee's Name		Employer's Name		() - Telephone Number	
Address		Employer's Address		City	State Zip
City	State Zip	Insurance Carrier		Policy Number	
() - Home Telephone		() - Work Telephone		Carrier's Address	
- -		/ /		City	State Zip
Social Security Number		Sex	Date of Birth	Carrier's Telephone Number	() - Fax Number

TO DEFENDANTS: Describe with particularity the body part(s) or condition(s) for which you are admitting liability and compensability.**TO EMPLOYEE:** Your employer admits your right to compensation for an☐ injury by accident on ____/____/____ (date) (Specify body part(s) involved):☐ occupational disease on ____/____/____ (date) (Specify condition(s) and body part(s) involved):**THE FOLLOWING ITEMS 1 THROUGH 4 ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY AND DO NOT CONSTITUTE AN AGREEMENT:**

- The description of the injury or occupational disease, including body parts involved is:
- The employee was paid for the entire day of injury. ☐ Yes ☐ No
- The employee's average weekly wage, subject to verification, including overtime and all allowances, was \$_____, which results in a weekly compensation rate of \$_____.
 - ☐ Temporary total compensation is being paid at the compensation rate above.
 - ☐ Temporary partial compensation is being paid in the amount of \$_____.
 - ☐ Other: _____
- The disability resulting from the injury began on ____/____/____ (date), and compensation commenced on ____/____/____ (date).

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR

TITLE

DATE

EMPLOYER: Failure to file Form 28B, Report of Compensation and Medical Compensation Paid, within 16 days after last payment pursuant to an agreement or award subjects employer or carrier/administrator to a penalty pursuant to N.C. Gen. Stat. §97-18(h). Form 30 must be used for compensable injuries resulting in death. A copy of this Form 60 shall be provided to the employee and the employee's attorney of record, if any, and the original provided to the Industrial Commission at the address below.